Division of Licensing and Protection
HC 2 South, 280 State Drive
Waterbury, VT 05671-2060
http://www.dail.vermont.gov
Survey and Certification Voice/TTY (802) 241-0480
Survey and Certification Fax (802) 241-0343
Survey and Certification Reporting Line: (888) 700-5330
To Report Adult Abuse: (800) 564-1612

May 19, 2016

Mr. Steven Doe, Manager
Our Lady Of The Meadows
1 Pinnacle Meadows
Richford, VT 05476-7637

Dear Mr. Doe:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **April 20, 2016.** Please post this document in a prominent place in your facility.

We may follow-up to verify that substantial compliance has been achieved and maintained. If we find that your facility has failed to achieve or maintain substantial compliance, remedies may be imposed.

Sincerely,

Pamela M. Cota, RN
Licensing Chief

PRINTED: 05/03/2016
FORM APPROVED

Division of Licensing and Protection

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 0197 | A. BUILDING: _____ B. WING _____ | C 04/20/2016 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| OUR LADY OF THE MEADOWS | 1 PINNACLE MEADOWS RICHFORD, VT 05476 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| R100 | Initial Comments:<br><br>An unannounced onsite investigation of seven entity reports was completed by the Division of Licensing and Protection from 4/19-20/16. The information gathered identified the following regulatory deficiencies. | R100 | | |
| R167 SS=D | V. RESIDENT CARE AND HOME SERVICES<br><br>5.10 Medication Management<br><br>5.10.d If a resident requires medication administration, unlicensed staff may administer medications under the following conditions:<br><br>(5) Staff other than a nurse may administer PRN psychoactive medications only when the home has a written plan for the use of the PRN medication which: describes the specific behaviors the medication is intended to correct or address; specifies the circumstances that indicate the use of the medication; educates the staff about what desired effects or undesired side effects the staff must monitor for; and documents the time of, reason for and specific results of the medication use.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on record review and staff interview, for 1 of 11 residents in the applicable sample (Resident #4), the Registered Nurse (RN) failed to develop a written plan for the use of an as needed (PRN) medication which describes specific behaviors the medication is intended to correct, as well as circumstances that indicate the use of the medication. Findings include:<br><br>1. During record review, the medical orders and | R167 | (PLEASE SEE ATTACHED) | |

Division of Licensing and Protection
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: ADMINISTRATOR | (X6) DATE: 5/16/16



R167-R224 POCs accepted 5/19/16 JHosmer RN/PMC

PRINTED: 05/03/2016
FORM APPROVED

Division of Licensing and Protection

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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|---|---|---|---|---|
| R167 | Continued From page 1<br>Medication Administration Record (MAR) for Resident #4 indicated that lorazepam 0.5 mg could be administered orally once daily as needed (PRN) agitation. The April MAR indicated that the medication had been administered once daily from 4/6 through 4/19/16. At 9:45 AM on 4/20/16 the RN confirmed that the facility could not provide a written behavioral plan for the use of the PRN lorazepam which would guide unlicensed staff in the administration of medication. | R167 | | |
| R178 SS=E | V. RESIDENT CARE AND HOME SERVICES<br><br>5.11 Staff Services<br><br>5.11.a There shall be sufficient number of qualified personnel available at all times to provide necessary care, to maintain a safe and healthy environment, and to assure prompt, appropriate action in cases of injury, illness, fire or other emergencies.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observations, staff interviews and record review, the facility failed to assure a sufficient number of qualified staff at all times to maintain a safe environment for 4 of 11 residents in the applicable sample (Residents #1, 2, 3, 4).<br>Findings include:<br><br>1. According to the facility's report and record review, on 4/2/16 Resident #1 was witnessed by staff when s/he grabbed the arm and pushed Resident #2. Record review and observations while on site 4/19-20/16 indicated that Resident #2 has Alzheimer's dementia and resides in the secure memory care unit. Resident #2 does not | R178 | (PLEASE SEE ATTACHED) | |



S-41

Division of Licensing and Protection

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 0197 | A. BUILDING: _____ B. WING _____ | C 04/20/2016 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| OUR LADY OF THE MEADOWS | 1 PINNACLE MEADOWS RICHFORD, VT 05476 |

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|---|---|---|---|---|
| R178 | Continued From page 2<br><br>have a history of aggression toward others. S/he engages in such behaviors as wandering and manipulating of objects in the environment, and can be redirected by staff. Resident #1 [who also resides in the secure memory care unit] has a known pattern of aggression toward other residents and has a diagnosis of dementia with behavioral disturbance, not easily altered. Supervision of Residents #1 and #2 was insufficient to prevent Resident #1 from getting hands on and pushing Resident #2 on 4/2/16.<br><br>2. According to the facility's report and record review, on 4/3/16 Resident #1 was witnessed by staff when s/he yelled and swore at and shoved Resident #3 while s/he was leaving a public bathroom. Record review and observations while on site 4/19-20/16 indicated that Resident #3 has dementia, anxiety, and depression, and resides in the secure memory care unit. S/he does not exhibit behavioral aggression to others. Resident #1 [who also resides in the secure memory care unit] has a known pattern of aggression toward other residents and has a diagnosis of dementia with behavioral disturbance, not easily altered. The supervision of Residents #1 and #3 was insufficient to prevent Resident #1 from verbally and physically abusing Resident #3 on 4/3/16.<br><br>3. According to the facility's report and record review, on 4/11/16 Resident #1 and Resident #4 were observed by staff having a discussion which escalated to an argument. Resident #4 hit Resident #1 with a stuffed animal, and Resident #1 responded by jumping at and grabbing the arm of Resident #4, taking him/her to the floor. There was prior established risk of aggression between Resident #1 and others, and prior evidence of aggression to others, including Resident #1, by Resident #4 . The staff failed to | R178 | | |



S43

Division of Licensing and Protection

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|---|---|---|---|---|
| R178 | Continued From page 3<br>anticipate the conflict between Resident #1 and #4 and intervene to prevent a physical altercation. | R178 | | |
| R224 SS=E | VI. RESIDENTS' RIGHTS<br><br>6.12 Residents shall be free from mental, verbal or physical abuse, neglect, and exploitation. Residents shall also be free from restraints as described in Section 5.14.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observations, staff interviews and record reviews, the facility failed to assure that 4 of 11 residents in the applicable sample (Residents #1, 2, 3, 4) were free from verbal and physical abuse. Findings include:<br><br>1. According to the facility's report and record review, on 4/2/16 Resident #1 was witnessed by staff when s/he grabbed the arm and pushed Resident #2. Record review and observations while on site 4/19-20/16 indicated that Resident #2 has Alzheimer's dementia and resides in the secure memory care unit. Resident #2 does not have a history of aggression toward others. S/he engages in such behaviors as wandering and manipulating of objects in the environment, and can be redirected by staff. Resident #1 [who also resides in the secure memory care unit] has a known pattern of aggression toward other residents (See 13523) and has a diagnosis of dementia with behavioral disturbance, not easily altered. On 3/30/16 the healthcare provider started twice daily oral doses of an anti-anxiety medication (lorazepam 0.5 mg orally). Supervision of Residents #1 and #2 was | R224 | (PLEASE SEE ATTACHED) | |



SAS

PRINTED: 05/05/2016
FORM APPROVED

Division of Licensing and Protection

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| R224 | Continued From page 4<br><br>insufficient to prevent Resident #1 from getting hands on and pushing Resident #2.<br><br>2. According to the facility's report and record review, on 4/3/16 Resident #1 was witnessed by staff when s/he yelled and swore at and shoved Resident #3 while s/he was leaving a public bathroom. Record review and observations while on site 4/19-20/16 indicated that Resident #3 has dementia, anxiety, and depression, and resides in the secure memory care unit. S/he does not exhibit behavioral aggression to others. Resident #1 [who also resides in the secure memory care unit] has a known pattern of aggression toward other residents (See 13523) and has a diagnosis of dementia with behavioral disturbance, not easily altered. The supervision of Residents #1 and #3 was insufficient to prevent Resident #1 from verbally and physically abusing Resident #3.<br><br>3. According to the facility's report and record review, on 4/11/16 Resident #1 and Resident #4 were observed by staff having a discussion which escalated to an argument. Resident #4 hit Resident #1 with a stuffed animal, and Resident #1 responded by jumping at and grabbing the arm of Resident #4, taking him/her to the floor. There was prior established risk of aggression between Resident #1 and others (see 13523, 14539, 14545), and prior evidence of aggression to others by Resident #4 (see 14545). The staff failed to anticipate the conflict between Resident #1 and #4 and intervene to prevent physical abuse. | R224 | | |

Our Lady Of The Meadows
Plan of Correction
Residential Care Home State Survey
April 20, 2016

**R167**

5.10.d (5)

**Action:** On April 20, 2016 the nursing staff developed a written plan for the use of the PRN medication for Resident #4 which describes the specific behaviors the medication is intended to correct or address; specifies the circumstances that indicate the use of the medication; educates the staff about what desired effects or undesired side effects the staff must monitor for; and document the time of, reason for and specific results of the medication use. (Please see Attachment A)

**Measures:** The Nurse Manager met with the entire nursing team to review the necessity of having a written plan for the use of the PRN medication which: describes the specific behaviors the medication is intended to correct or address; specifies the circumstances that indicate the use of the medication; educates the staff about what desired effects or undesired side effects the staff must monitor for; and document the time of, reason for and specific results of the medication use.

**Monitors:** Nurse Manager and entire Nursing team will monitor this practice to insure that this deficiency does not reoccur.

**Date Completed:** 4/21/2016

**R178**

5.11.a

**Actions:**

Relevant Actions include:

*Resident #1*

On 3/17/16 it was noted that Resident #1 was not sleeping through the night and was up wandering into other Resident's room.

On 4/4/16 Resident #1 was placed on a dedicated supervised walking program, twice daily (AM and PM) to assist in lessening agitation and anxiety.

On 4/2/16 Staff were supervising Resident #1 as he/she experienced sudden and unpredictable onsets of aggression. Supervising staff intervened when Resident #1 became verbally aggressive to Resident #2. Nursing notified PCP, APS, DLP and family

On 4/3/16 Staff were supervising Resident #1 as s/he experienced sudden and unpredictable onsets of aggression. Supervising staff intervened when Resident #1 suddenly became aggressive toward Resident #4. Nursing notified PCP, APS, DLP and family.

On 4/4/16 Nursing noted:

Resident #1 urine was checked for UTI and is negative

Pain was addressed with scheduled Tylenol

Bowel Pattern monitored as able and no evidence of constipation

Resident #1 taken for walks several times each day to reduce restlessness and monitored by staff for increased anxiety and provide redirection to bedroom, Sensory Room or nther quiet location with staff monitoring

On 4/5/16 Administrator and Nurse Manager met with Spouse of Resident #1 to present discharge notice and discuss plan for seeking alternate placement.

On 4/11/16 Resident had an altercation with Resident #4. Notified PCP, APS, DLP and Spouse. Effective as of today, Resident #1 was assigned a One-to-One dedicated staff member to supervise and monitor behaviors from 4:00pm – 8:30pm seven days a week as this seems to be the time when agitation and anxiety tends to increase.

On 4/12/16 Nursing requested pharmacological intervention to assist with Resident #1 anxiety and agitation. PCP unwilling to prescribe any additional medications at this time. PCP referred Resident #1 to The Memory Center.

By 4/12/16 no alternative placement has been found for Resident #1.

On 4/19/16 The Administrator accompanied Resident #1 to an appointment at The Memory Center. Spouse was present for appointment. APRN at The Memory Center ordered 0.25mg Risperidone to be given BID. APRN asked why Resident

#1 was not already taking Risperidone "as (Resident #1) should have been taking it long before now". The Administrator stated that the PCP was unwilling to prescribe it. The APRN stated that the PCP "needs to realize that his/her patients need it."

On 4/20/16 Resident #1 started taking 0.25mg Risperidone as ordered

On 5/4/16 Staff were supervising Resident #1 as s/he experienced sudden and unpredictable onsets of aggression. Supervising staff intervened when Resident #1 suddenly moved and grabbed another Resident's wrist. Nursing notified PCP, APS, DLP and family.

On 5/16/16 Nursing noted that Resident #1 is now sleeping better and is not up wandering at night. S/he is able to sit at mealtime to eat and has also experience some weight gain. It was also noted that Resident #1 is more socially appropriate, is more easily redirected and has experience no sudden aggressive outbursts since 5/4/16.

*Resident #4*

On 3/28/16 Nursing notified PCP about Resident #4 increase in agitation and requested a medical intervention to help reduce his/her anxiety. PCP ordered Tylenol to address potential pain.

On 4/2/16 Nursing reported that Resident #4 was up most of the night wandering around. S/he was unable to verbalize the cause of his/her anxiety. S/he was supervised by staff, provided food, drinks and assisted to the toilet in an attempt to alleviate anxiety with some relief. S/he then became upset later in the day accusing others of stealing her things

On 4/7/16 Nursing reported that Resident #4 was agitated most of the night, up wandering and banging on doors. Staff was present and supervising to prevent Resident #4 from waking others.

On 4/7/16 Staff were supervising Resident #4 as he/she experienced sudden and unpredictable onsets of aggression. Resident #4 suddenly became aggressive toward Resident #1. Supervising staff worked hard to intervene, validate and redirect Resident #4. Urine was checked for UTI, it was negative. Administered Tylenol for pain with minimal results. PCP, APS, DLP and family was notified. Nurse sat with Resident #4 for lengthy periods. Nursing requested more frequent walks and to take Resident #4 to another wing for Activities with other faces.

Nursing spoke the Resident #4's son. Son requested contacting the PCP to increase medication to assist with anxiety.

On 4/7/16 Resident #4 was placed on a dedicated supervised walking program, twice daily (AM and PM) to assist in lessening agitation and anxiety.

On 4/7/16 Nursing spoke with office of PCP. PCP is considering adding Benadryl to Resident #4's medication regimen. Nursing stated that it might be helpful, but again requested Lorazepam as a PRN to be available for anxiety with agitation.

On 4/7/16 PCP ordered 0.5mg Lorazepam at bedtime for anxiety. Resident #4 was giving first dose of Lorazepam at bedtime.

On 4/8/16 Nursing noted that Resident #4 slept all night and awoke clear, in a pleasant mood and stating that she feels so much better.

On 4/11/16 Staff were supervising Resident #4 as s/he experienced sudden and unpredictable onsets of aggression. Resident #4 suddenly became aggressive toward Resident #1. Nursing notified APS, DLP and family. Nursing also notified PCP and requested an increase of Lorazepam to twice a day as needed. PCP refused further medication at this time. PCP referred Resident #4 to The Memory Center.

On 4/21/16 Resident #4 was taken to The Memory Center for an initial appointment. The provider at The Memory Center did not order any medication changes at this time. Follow up appointment at The Memory Center is scheduled for 5/20/16.

On 4/20/16 Staff were supervising Resident #4 as s/he experienced sudden and unpredictable onsets of aggression. Resident #4 suddenly became aggressive toward another resident and push the resident to the floor. PCP, APS, DLP and family was notified. Nursing again requested an increase of Lorazepam to twice daily until other medication changes can be made. PCP denied the request.

Additional Actions include seeking alternate Medical Providers who have experience with managing challenging behaviors.

**Measures:** Resident #1 and Resident #4 continue to participate in supervised walks several times a day and is supervised by staff for increased anxiety and provide redirection to bedroom, Sensory Room or other quiet location with staff monitoring. Further measures include carefully monitoring the interaction between Resident #1, Resident #4 and other residents.

Resident #1 also continues to have a One-to-One dedicated staff member daily to supervise and monitor behaviors from 4:00pm – 8:30pm.

Additionally, The Nurse Manager has developed a policy regarding Strategy for Managing Challenging Behaviors. (Please see Attachment B) This policy has been instituted at Our Lady Of The Meadows and the Nurse Manager has thoroughly reviewed this policy with the Nursing Staff.

**Monitors:** The Administrator, Nurse Manager and Licensed Nursing Staff will work to insure that this deficiency will not reoccur.

**Date Completed:** 05/13/2016

**R224**

6.12

**Actions**

Relevant Actions include:

*Resident #1*

On 3/17/16 it was noted that Resident #1 was not sleeping through the night and was up wandering into other Resident's room.

On 4/4/16 Resident #1 was placed on a dedicated supervised walking program, twice daily (AM and PM) to assist in lessening agitation and anxiety.

On 4/2/16 Staff were supervising Resident #1 as he/she experienced sudden and unpredictable onsets of aggression. Supervising staff intervened when Resident #1 became verbally aggressive to Resident #2. Nursing notified PCP, APS, DLP and family

On 4/3/16 Staff were supervising Resident #1 as s/he experienced sudden and unpredictable onsets of aggression. Supervising staff intervened when Resident #1 suddenly became aggressive toward Resident #4. Nursing notified PCP, APS, DLP and family.

On 4/4/16 Nursing noted:

Resident #1 urine was checked for UTI and is negative

Pain was addressed with scheduled Tylenol

Bowel Pattern monitored as able and no evidence of constipation

Resident #1 taken for walks several times each day to reduce restlessness and monitored by staff for increased anxiety and provide redirection to bedroom, Sensory Room or other quiet location with staff monitoring

On 4/5/16 Administrator and Nurse Manager met with Spouse of Resident #1 to present discharge notice and discuss plan for seeking alternate placement.

On 4/11/16 Resident had an altercation with Resident #4. Notified PCP, APS, DLP and Spouse. Effective as of today, Resident #1 was assigned a One-to-One dedicated staff member to supervise and monitor behaviors from 4:00pm – 8:30pm seven days a week as this seems to be the time when agitation and anxiety tends to increase.

On 4/12/16 Nursing requested pharmacological intervention to assist with Resident #1 anxiety and agitation. PCP unwilling to prescribe any additional medications at this time. PCP referred Resident #1 to The Memory Center.

By 4/12/16 no alternative placement has been found for Resident #1.

On 4/19/16 The Administrator accompanied Resident #1 to an appointment at The Memory Center. Spouse was present for appointment. APRN at The Memory Center ordered 0.25mg Risperidone to be given BID. APRN asked why Resident #1 was not already taking Risperidone "as (Resident #1) should have been taking it long before now". The Administrator stated that the PCP was unwilling to prescribe it. The APRN stated that the PCP "needs to realize that his/her patients need it."

On 4/20/16 Resident #1 started taking 0.25mg Risperidone as ordered

On 5/4/16 Staff were supervising Resident #1 as s/he experienced sudden and unpredictable onsets of aggression. Supervising staff intervened when Resident #1 suddenly moved and grabbed another Resident's wrist. Nursing notified PCP, APS, DLP and family.

On 5/16/16 Nursing noted that Resident #1 is now sleeping better and is not up wandering at night. S/he is able to sit at mealtime to eat and has also experience some weight gain. It was also noted that Resident #1 is more socially appropriate, is more easily redirected and has experience no sudden aggressive outbursts since 5/4/16.

*Resident #4*

On 3/28/16 Nursing notified PCP about Resident #4 increase in agitation and requested a medical intervention to help reduce his/her anxiety. PCP ordered Tylenol to address potential pain.

On 4/2/16 Nursing reported that Resident #4 was up most of the night wandering around. S/he was unable to verbalize the cause of his/her anxiety. S/he was supervised by staff, provided food, drinks and assisted to the toilet in an attempt to alleviate anxiety with some relief. S/he then became upset later in the day accusing others of stealing her things

On 4/7/16 Nursing reported that Resident #4 was agitated most of the night, up wandering and banging on doors. Staff was present and supervising to prevent Resident #4 from waking others.

On 4/7/16 Staff were supervising Resident #4 as he/she experienced sudden and unpredictable onsets of aggression. Resident #4 suddenly became aggressive toward Resident #1. Supervising staff worked hard to intervene, validate and redirect Resident #4. Urine was checked for UTI, it was negative. Administered Tylenol for pain with minimal results. PCP, APS, DLP and family was notified. Nurse sat with Resident #4 for lengthy periods. Nursing requested more frequent walks and to take Resident #4 to another wing for Activities with other faces. Nursing spoke the Resident #4's son. Son requested contacting the PCP to increase medication to assist with anxiety.

On 4/7/16 Resident #4 was placed on a dedicated supervised walking program, twice daily (AM and PM) to assist in lessening agitation and anxiety.

On 4/7/16 Nursing spoke with office of PCP. PCP is considering adding Benadryl to Resident #4's medication regimen. Nursing stated that it might be helpful, but again requested Lorazepam as a PRN to be available for anxiety with agitation.

On 4/7/16 PCP ordered 0.5mg Lorazepam at bedtime for anxiety. Resident #4 was giving first dose of Lorazepam at bedtime.

On 4/8/16 Nursing noted that Resident #4 slept all night and awoke clear, in a pleasant mood and stating that she feels so much better.

On 4/11/16 Staff were supervising Resident #4 as s/he experienced sudden and unpredictable onsets of aggression. Resident #4 suddenly became aggressive toward Resident #1. Nursing notified APS, DLP and family. Nursing also notified PCP and requested an increase of Lorazepam to twice a day as needed. PCP refused further medication at this time. PCP referred Resident #4 to The Memory Center.

On 4/21/16 Resident #4 was taken to The Memory Center for an initial appointment. The provider at The Memory Center did not order any medication changes at this time. Follow up appointment at The Memory Center is scheduled for 5/20/16.

On 4/20/16 Staff were supervising Resident #4 as s/he experienced sudden and unpredictable onsets of aggression. Resident #4 suddenly became aggressive toward another resident and push the resident to the floor. PCP, APS, DLP and family was notified. Nursing again requested an increase of Lorazepam to twice daily until other medication changes can be made. PCP denied the request.

Additional Actions include seeking alternate Medical Providers who have experience with managing challenging behaviors.

**Measures:** Resident #1 and Resident #4 continue to participate in supervised walks several times a day and is supervised by staff for increased anxiety and provide redirection to bedroom, Sensory Room or other quiet location with staff monitoring. Further measures include carefully monitoring the interaction between Resident #1, Resident #4 and other residents.

Resident #1 also continues to have a One-to-One dedicated staff member daily to supervise and monitor behaviors from 4:00pm – 8:30pm.

Additionally, The Nurse Manager has developed a policy regarding Strategy for Managing Challenging Behaviors. (Please see Attachment B) This policy has been instituted at Our Lady Of The Meadows and the Nurse Manager has thoroughly reviewed this policy with the Nursing Staff.

**Monitors:** The Administrator, Nurse Manager and Licensed Nursing Staff will work to insure that this deficiency will not reoccur.

**Date Completed:** 05/13/2016

ATTACHMENT D

# Strategy for managing challenging behaviors POLICY



## What needs to happen...

Staff must be skilled in working with confused residents so that challenging behavior is avoided whenever possible, and is handled with dignity and compassion when it occurs.

### Why it's important...

Confused residents may occasionally behave in a challenging way due to their condition. The right reaction can make residents feel comfortable and secure.

## How to make it happen...

Minimize the discomfort of confused residents. Challenging behavior is often a resident's way of telling you he or she is uncomfortable or unhappy about something. A resident may be afraid, tired, bored, lonely, hungry, or in pain but cannot tell you. Behavior may be your only clue. Your response to a resident can limit challenging behavior.

Some examples of challenging behavior are wandering, elopement (leaving the building alone), agitation, repetitive behavior, and inappropriate sexual behavior.

**Wandering:**

Make sure the resident gets exercise and activity during the day. Be sure that wandering does not occur because the resident is hungry or looking for the bathroom. If the behavior is new, check to see if a new medication might be causing it, or when the person last moved their bowels.

Wandering can be dangerous for the resident or interfere with the rights of other residents (such as wandering into another resident's room). Encourage a resident who wanders to do so in a way that is safe.

The Assisted Living Policy Manual
v 1.0

# Strategy for managing challenging behaviors Policy *(continued)*



**Agitation and Aggression:**

Do:

1. Determine the cause of the agitation or aggression, if able.
   a. Offer Foods, Drinks
   b. Take to Bathroom
   c. Look for signs of pain
   d. Lie down for a nap
2. Be supportive and encouraging.
3. Use The Validation Technique to address the resident's concerns
4. Clearly communicate with the resident using like tone and good eye contact. Use clear simple language, giving the resident time to process the question/request and respond.
5. Use positive expressions such as:
   a. Please.
   b. Thank you.
   c. Let me see if I can help.
6. Bringing in more staff and more noise may only make the situation worse. Reduce stimulation; for instance, turn off radios, televisions, anything that is making a loud noise.
7. Involve the resident in the Walking Program and/or take the resident to a quiet area within the facility or even outside for a walk (weather permitting). If the reduced stimulation helps in lessening the behavior, develop a plan to maintain this type of environment for the resident as often as possible.
8. Remove from crowded areas.
9. Utilize Sensory Room or Terrace
10. Place "Stop" or 'Closed" signs across doorways to help prevent wandering residents from entering other resident's rooms.

# Strategy for managing challenging behaviors

**POLICY** *(continued)*



11. Assign a staff member to provide One-To-One supervision to the resident who is exhibiting agitation and/or aggression.

12. Ensure that all other residents are safe from any resident who is exhibiting agitation and/or aggressive behavior.

13. Notify the nurse or nurse on-call as pharmacological intervention may be necessary. Refer to Psychotropic Care Plan prior to notifying the nurse.

14. Notify the family member/POA/Guardian and set up a consult with the Primary Care Physician to explore medical options to help the resident to feel less anxious/aggressive. If needed, request a referral to a geriatric/memory care specialist.

15. It may be necessary to discharge the aggressive resident from the facility if his/her behavior is uncontrollable and this puts other residents at risk.

Do not:

1. Scold the resident.
2. Humiliate the resident.
3. Force a resident to do a task.
4. Intimidate the resident.
5. Restrain the resident.
6. Corner or crowd the resident with too many staff.

**TIP**

- Warning signs of agitation include:
  - ✓ Frowning.
  - ✓ Pacing.
  - ✓ Waving arms.
  - ✓ Speaking loudly.
  - ✓ Rattling doorknobs.
  - ✓ Wringing hands.
  - ✓ Scowling.
  - ✓ Shaking fists.
  - ✓ Backing away from others.
  - ✓ Trying to leave the building.
  - ✓ Being unable to sit still or rest.

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# Strategy for managing challenging behaviors Policy *(continued)*



**Repetitive Behaviors:**

Actions that someone performs continuously or on a repeated basis:

1. Let the resident perform the behavior if it isn't hurting him or her or others or disturbing others.
2. Look behind the behavior and try to understand what is causing it.
3. Calm fears, provide a quiet atmosphere, talk with him or her, give the resident a task to do.

**Acceptable vs. Unacceptable Sexual Behavior:**

In the case of displays of affections between residents when one is mentally competent and the other has a medical diagnosis of dementia, Alzheimer's Disease or any other condition in which the resident is not deemed competent to make decisions for him/herself; the staff will make every effort to intervene in order to protect the right of the individuals involved and notify the Nurse as soon as possible.

In the case of two residents when both are deemed incapable of making decisions for themselves, the staff should observe carefully, intervene as necessary and notify the Nurse as soon as possible.

Some behaviors that are considered **appropriate** are the following:

1. Hand holding
2. Sitting Close together and having arms around each other to the extent that neither resident is expressing or appears to be uncomfortable with the situation.
3. Brief kissing to the extent that neither resident is expressing or appears to be uncomfortable with the situation.

The staff should be able to observe these residents at all times, either in a common area or in their rooms with the doors open.

Some behaviors that are considered **inappropriate** are the following:

1. Prolonged Kissing

# Strategy for managing challenging behaviors

## POLICY (continued)



2. Fondling
3. Disrobing
4. Vulgar or suggestive language
5. Any type of sexual intercourse

The staff should intervene to prevent this behavior without over reacting, embarrassing or humiliating the residents and notify the nurse as soon as possible. The nurse will be responsible for notifying the Families/POA's/Guardians of the residents involved.

Interventions could include:

1. Separating the individuals
2. Redirection and using the Validation Technique
3. Encouraging the joining of group or individual activities
4. Offering a snack
5. One to One with staff or family
6. Music/TV
7. Going for a walk with a staff member

In the case where staff intervention has been unsuccessful, the nurse will consult with the Families/POA's/Guardians and management to decide a plan of action that is based on the wants and needs of the residents.

Public displays of masturbation, undressing, and inappropriate touching:

1. Residents may masturbate because they may no longer be aware of appropriate times or places for sexual behaviors or their sexual needs are not being met.
2. Residents may undress because their clothes are too tight, their clothes may be itchy or uncomfortable, or they may be too warm.
3. Residents may touch themselves because they need to go to the bathroom, they have a urinary tract infection (UTI), they have a

# Strategy for managing challenging behaviors Policy *(continued)*



rash, or it feels good, and they have lost the ability to judge the appropriateness of their own behavior.

4. Residents may touch others because they misunderstood or misinterpreted staff ("Shall we get your bath?" "Let's go to bed."), they have lost their inhibitions, or they are being flirtatious.

There are many ways that you can help a confused resident who displays inappropriate sexual behaviors. Don't take the behavior personally, but look to see if you may have done something that could be misinterpreted.

You can help by:

1. Remembering to act in a way that preserves the resident's dignity.
2. Do not overreact and approach the resident in a calm manner.
3. Try using the Validation Technique to help alleviate the situation.
4. Do not scold the resident.
5. Do not embarrass or humiliate the resident.
6. Do not force a resident to do a task.
7. Do not intimidate or restrain the resident.
8. Do not corner or crowd the resident with too many staff.
9. Never judge a resident because of the behavior.
10. Discretely offering privacy to the resident.
11. Checking the resident's groin area for a rash or urinary tract infection (UTI).
12. Remembering that the bebavior may be caused by the need to use the bathroom — try escorting the resident to the bathroom.
13. Trying to find out what is causing the behavior. For instance, are the resident's clothes too tight?